# REPORT BY THE AUDITOR GENERAL OF CALIFORNIA

## THE MARTIN LUTHER KING JR. FAMILY HEALTH CENTER NEEDS TO IMPROVE ITS FINANCIAL OPERATIONS

P-021 APRIL 1991

# The Martin Luther King Jr. Family Health Center Needs To Improve Its Financial Operations

P-021, April 1991

Office of the Auditor General
California

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April 17, 1991 P-021

Honorable Robert J. Campbell, Chairman
Members, Joint Legislative Audit Committee
State Capitol, Room 2163
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the fiscal operation of the Martin Luther King Jr. Family Health Center. The report concludes that the center needs to improve its financial condition and immediately strengthen its controls over its financial operations, including billing and collecting for reimbursement of health care services, managing its professional services contracts and its purchasing and cash disbursement operations, and improving its accounting and administrative operations.

Respectfully submitted,

KURT R. SJOBERG
Auditor General (acting)

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# Summary

## Results in Brief

The West Contra Costa Community Health Care Corporation, through its Martin Luther King Jr. Family Health Center (center), provides health care services to approximately 10,000 low-income and medically underserved individuals, through a variety of health care plans. For fiscal year 1989-90, the center received more than $2.2 million, derived primarily from federal and state sources for health care services it provided to its patients. However, for several years, the center has had difficulty in managing its funds. As of March 31, 1991, the center continues to have financial difficulties, and it needs to improve its billing and collecting for the reimbursement of health care services, its controls over its professional services contracts, its purchasing and cash disbursements operations, and its accounting and administrative operations. Because the center has poorly handled its fiscal responsibilities, we found the following conditions during our review of the center:

- It released its staff and eliminated all services except prenatal between late July and October 1990;
- In October 1990, with the help of a $110,000 advance from the federal Department of Health and Human Services (DHHS), the health center began to reopen;
- Even though the center continues to operate and provide health care to the community, as of March 31, 1991, it owed $350,000 to various creditors;

- In December 1990, the DHHS approved the center for a second advance of funds from its federal grant for fiscal year 1991-92 but imposed several conditions. Among them, the DHHS informed the center that either the center solve its cash flow problems by March 31, 1991, or the DHHS would not advance any additional federal funds to the center, and the center would have to either close or operate without the DHHS' support;

- As of February 1991, the center has nearly $107,800 due from reimbursements of health care services it provided to patients through its health plans, such as the California Medical Assistance Program (Medi-Cal), Self-Pay, and Private Insurance; however, it still has not billed for these services even though it provided them to patients in earlier months;

- The center was without a fiscal officer between November 1989 and May 1990 and between August and November 1990;

- During fiscal year 1989-90, the center made payments to contractors without, among other conditions, obtaining appropriate documentation from the contractor to show that such payments had been earned, without paying contractors according to the terms specified, without seeking competition before awarding contracts, and without properly writing up the terms of the contracts;

- During fiscal year 1989-90, the center paid more than $8,600 for goods and services that may have been unnecessary for the center's operations, and it paid vendors more than $9,600 for goods and services it may not have received;

- Three former employees have filed claims with the State Division of Labor Standards Enforcement for more than $65,000 alleging that they were not fully compensated for their accumulated vacation leave;

- The center did not always promptly remit to the appropriate tax agencies funds that it withheld from employee paychecks for payroll taxes. For example, the center did not promptly remit at least $97,000 of federal payroll taxes for July through December 1989 and it has not remitted at least $100,000 of state and federal payroll taxes for January through June 1990; and

- The center incurred at least $16,000 in late charges, penalties, and interest because it did not pay its bills promptly.

**Background**

Fifteen members, who primarily represent the Richmond area, which the center serves, constitute the board of directors, who oversee the center's operations. The center provides various services such as family medicine, psychosocial counseling, prenatal, laboratory, and optometry services. It provides these health care services to individuals through health programs that reimburse the center based on a fee-for-service. Further, between November 1986 and May 1990, the center contracted with the Department of Health Services (department) to provide services to beneficiaries eligible for Medi-Cal through the Primary Care Case Management (PCCM) program.

For several years, the center has had difficulties meeting its financial obligations. According to the former executive director, these difficulties date back to at least 1985 when the center began to experience its greatest growth in the number of patients it served. Several events have contributed to the center's financial hardship. For example, the eventual loss of the PCCM program in May 1990 exacerbated the center's cash flow problems. Also,

on numerous occasions, the center borrowed money to meet its staff payroll, thereby, increasing its outstanding debts. Finally, in July 1990, the center terminated its executive director and released some of its staff and began to eliminate all services except prenatal. In October 1990, the center began to reopen with a predominantly new board and staff. However, the center has continued to have financial difficulties, thus, jeopardizing the continuance of its federal funds.

## The Center Continues To Have Financial Difficulties

Although the center was able to begin to reopen in October 1990, the center continues to have financial difficulties. As a result, the center has relied on short-term loans to meet its most critical financial needs, and it has obtained two advances of funds from its federal grant for 1991-92. However, to receive the second advance of funds, the center agreed to submit to the DHHS an operating plan and a plan to resolve its indebtedness. On March 21, 1991, the center submitted these plans to the DHHS. In its operating plan, the center projects that it will realize an operating loss of approximately $362,000 for the 12 months ending March 31, 1992. In addition, the center estimates that it needs approximately $852,000 to continue to operate through March 31, 1992. We reviewed the center's operating plan and found that the center's projected operating loss of $362,000 is a reasonable approximation. We also reviewed the center's plan to resolve its indebtedness. We found that, while the center's estimate of its debt and funding requirements is reasonable, the center's analysis understates by about $60,000 the amount of funds it should be able to generate to pay its debts. Our analysis assumes that the center will implement the necessary controls and improvements in its financial operations that we discuss in the rest of this report. Unless it immediately improves its financial operations, we believe that the center will be unable to meet its revenue projections or adequately control its operating costs.

## The Center Needs To Improve Its Billing and Collecting for Reimbursement of Health Care Services

For reimbursement of health care services, the center does not bill properly or quickly enough to meet its financial obligations. Also, the center does not bill for immunizations at rates that allow it to recover its cost for providing the service. Further, the center does not account for or retain important documents used to bill for health care services, nor does it routinely collect outstanding amounts owed for health care services it provides to patients. Because the center did not bill quickly enough, it has experienced delays in receiving the revenue needed to meet its financial obligations. For example, the center has not billed for nearly $107,800 worth of health care services it provided to patients in December 1990 and January 1991, thus, contributing to its inability to meet its payroll. Also, because the center does not bill properly or at the appropriate rates and does not routinely collect amounts owed for health care services it provides to patients, the center lost revenue. For example, the center lost approximately $1,760 in revenue because it did not bill for patients' use of the examining and treatment room for 81 patient encounter forms we reviewed from September 1989 through October 1990. More importantly, we estimate the center lost more than $177,000 for not billing for the examining and treatment room for the estimated 8,170 Medi-Cal patients it served during fiscal year 1989-90. (Encounter forms are the documents the center's clinical staff prepare and complete for each patient. The staff enter on the form procedures codes to indicate the services that the patient receives.)

## The Center Needs To Improve Its Controls Over Its Professional Services Contracts and Its Purchasing and Cash Disbursements Operations

The center needs to improve its controls over its professional services contracts and its purchasing and cash disbursements operations. For example, for its professional services contracts, the center did not obtain appropriate documentation from contractors, pay contractors according to the terms specified, amend contracts to reflect changes, seek competition before awarding contracts, and properly write up the terms of its contractual agreements. For example, during fiscal year 1989-90, in one instance of not obtaining appropriate documentation, the center paid one of its contractors, a marketing representative, more than $26,000 in commissions to enroll patients into the PCCM program.

However, we could find no evidence to show the names of all of the individuals the representative enrolled in the program, as required by the contract.

In addition, for its purchasing and cash disbursements, the center has not followed sound internal controls to ensure that purchases and cash disbursements are authorized and that disbursements are made only for goods and services received. As a result, the center may have paid for unnecessary goods and services, and for goods and services it did not receive.

## The Center Needs To Improve Its Controls Over Its Accounting and Administrative Operations

The center has not maintained accounting records adequately enough to monitor amounts owed to vendors and other creditors. As a result, as of June 30, 1990, the center had understated its liabilities by at least $100,000. In addition, the center has not maintained adequate records or established adequate safeguards to protect its property and equipment. As a result, the center has lost some property and equipment, including a 1975 Chevrolet sedan. Also, the center has not maintained adequate controls over its payroll activities. Specifically, the center has not always ensured that services were received before it issued payroll checks, and it did not promptly remit at least $97,000 of federal payroll taxes for 1989 and it has not remitted at least $100,000 of state and federal payroll taxes for January through June 1990. Finally, the center has not separated incompatible duties within its accounting office. As a result, some employees perform duties that could allow them to both perpetrate and conceal a fraudulent act.

## Recommendations

To improve its financial operations, the board of directors should ensure that the Martin Luther King Jr. Family Health Center takes the following actions:

- Pursue all available sources of funding;

- Immediately take steps to reduce the backlog of patient encounter forms that have not been billed. Once this is accomplished, the center should bill promptly and properly for the reimbursement of health care services it provides to patients;

- Routinely collect outstanding amounts owed for the reimbursements of health care services it provides to patients;

- Develop and implement procedures to ensure that disbursements are appropriate and properly authorized and that contracts are properly managed;

- Develop and implement procedures to monitor and manage its liabilities and to ensure that property and equipment are safeguarded from loss or misuse; and

- Ensure that payroll procedures provide adequate controls. These controls should include measures to ensure that services are verified before payroll checks are issued.

**Agency Comments**

The Martin Luther King Jr. Family Health Center basically agrees with the findings and recommendations in our report.

## Introduction

The West Contra Costa Community Health Care Corporation, through its Martin Luther King Jr. Family Health Center (center), provides health care services to approximately 10,000 low-income and medically underserved individuals annually. Fifteen board members, who primarily represent the Richmond area, which the center serves, constitute the board of directors (board), which oversees the center's operations. The center's executive director is responsible for the administration of the center. The center provides services such as family medicine, psychosocial counseling, prenatal, laboratory, and optometry services. In fiscal year 1989-90, it operated on a $2.2 million budget, and most of the revenue came from the federal Department of Health and Human Services and state sources.

The center provides health care services to individuals through health programs, such as the California Medical Assistance Program (Medi-Cal), Child Health and Disability Prevention, Family Planning, and Medicare and Private Insurance. All of these programs reimburse the center for health care services it provides to patients based on a fee-for-service. The center also provides services to individuals through a self-pay plan; that is, patients pay for the services themselves. Further, between November 1986 and May 1990, the center had a contract with the Department of Health Services to provide services to beneficiaries eligible for Medi-Cal through the Primary Care Case Management (PCCM) program. The PCCM program is a prepaid health care plan through which providers such as the center provide medical services to individuals eligible for Medi-Cal. Providers are reimbursed by the department for each month a patient is enrolled in the program.

## The Center's History of Financial Problems[1]

After 12 years of operation, the center's financial condition became so critical that, in June 1990, the federal Department of Health and Human Services (DHHS) released an audit report that criticized the center for poor fiscal management. According to the board minutes of June 27, 1990, the DHHS indicated that the center would have to terminate its senior management before it would provide the center with additional federal funds. On July 6, 1990, the board terminated its former executive director and temporarily assigned its fiscal officer to the position of interim executive director. At this time, the board acknowledged that the center may have to reduce its staff and the services provided to its patients. According to the board minutes of August 7, 1990, the board discussed filing a Chapter 11 petition for protection from creditors under the United States bankruptcy laws. However, the board decided not to file the petition because it hoped to receive funds from both state and federal grants. However, the center did not receive the funds it anticipated and, later, began to release its clinical and administrative staff and eliminate all services except prenatal care.

The former executive director stated that the center's financial troubles date back to at least 1985 when the center began to experience its greatest growth in the number of patients it served. (Table 1 in the Appendix shows the center's comparative statement of revenue and expenses for fiscal year 1985-86 through 1988-89, and Table 2 shows a comparative balance sheet for the same years.) The following discussion outlines several events that help explain the center's current financial hardship.

According to the former executive director, between fiscal year 1985-86 and 1989-90, the center expanded the services that it provided to its patients, and with hindsight, it appears that this

[1] We derived our information on the center's history of financial problems up to the closing of the center from minutes of the center's board of directors' meetings held from September 1989 to February 1991 and a summary document from the former executive director; however, we did not validate the accuracy of the information contained in these documents.

expansion contributed to the center's subsequent financial problems since the expansion in services entailed some start-up costs, high administrative costs, and an increase in the center's payroll expenses. During the same period, to provide additional services to its patients and to generate additional revenue, the center expanded its services by opening a pharmacy, by offering home health care services, by establishing the PCCM program, and by providing dental care.

According to the former executive director, the PCCM was the most complex and demanding of the programs to implement and manage, and it involved high administrative costs. For example, the PCCM contract required the center to provide certain mandatory services, such as physician, obstetric care, pharmacy, pathology, vision care, and psychiatric services. The PCCM also required the center to provide quarterly financial reports and annual audits, a system for providing continuity of care, including patient referrals, and a means of monitoring members enrolled in the plan with on-going medical conditions. Additionally, the PCCM program required the center to be responsible for all marketing activities, including those of marketing representatives. Further, the PCCM contract required the center to appoint a medical director. The center implemented all the new services, including the PCCM program, without additional funds for start-up costs. For example, to prepare for the PCCM's program implementation, the center made a major purchase that strained its budget. In January 1987, the center entered into an agreement to lease a $110,000 computer system, at a cost of $2,500 per month, to manage the cases of patients enrolled in the PCCM program. In September 1987, in an attempt to facilitate the start of the programs, the center borrowed $225,000, which it secured with its building. It used some of these funds to repay loans and then had only $78,720 remaining for start-up capital to implement the new services discussed above.

According to the former executive director, between fiscal year 1985-86 and 1989-90, the center experienced its greatest growth because it expanded its services. However, with this growth, the center created new financial obligations for itself. For

example, at this time, the center increased its payroll. Also, the center had to account for the sources of revenue from the additional services, making the task of administering its service resources more complex.

According to the former executive director, the program that created considerable difficulty for the center was the PCCM program. In reviews of this program, the center was repeatedly cited for not operating the program in accordance with its contract with the Department of Health Services (department). Some of these difficulties affected the center's financial condition. Between fiscal year 1986-87 and 1989-90, the department and an independent certified public accounting firm conducted several annual compliance and financial audits, all required as a part of the center's contract with the department. In these audits, the center was cited for numerous deficiencies in its operations. Each of these deficiencies required correction, and implementing these corrections affected the center's financial condition.

Despite attempts to improve the management of its PCCM program, the center continued not to fulfill its contractual obligations. Consequently, the department terminated the center's PCCM contract on May 31, 1990, despite the center's request to appeal the department's decision. The loss of the PCCM program resulted in the center losing about $450,000 a year in revenue based on its contract for fiscal year 1989-90. However, this revenue loss was probably offset by a reduction in expenses associated with the PCCM program.

The center also experienced numerous financial problems with the other services it implemented: dental, pharmacy, and home health care. For example, according to the former executive director in the minutes of a board meeting on January 30, 1990, the center was losing money on its dental program because the center's costs to provide dental care were greater than the reimbursement it received for the services. In the minutes from another board meeting, the fiscal officer indicated that, by June 1990, the dental program was losing approximately $90,000 per year.

According to the former executive director, the initiation of the center's pharmacy placed a strain on its budget. For example, in August 1987, the center purchased a computer system for its pharmacy. By October 31, 1990, the cost associated with the system had reached nearly $25,000, all of which has remained unpaid as of March 31, 1991. In an audit report conducted in 1988, the department criticized the center's management of its pharmacy for inadequate procedures and insufficient inventory. These problems identified in the audit report may have contributed to the center's inability to retain its pharmacists. In March 1989, the center's pharmacist resigned. According to another pharmacist, the center was not able to hire a replacement until May 1989. In February 1990, nine months later, the replacement pharmacist resigned and cited as reasons for leaving that the center's business practices were improper and that the administration was deceptive.

The Home Health Care program was another problem area for the center. According to the board's minutes of February 8, 1990, the center was requested to repay $57,205 to Medicare for an inappropriate adjustment in the reimbursement rate disclosed in an audit conducted in fiscal year 1987-88 of the program; however, the center requested an appeal of the decision.

## Repeated Warnings

Repeatedly, the center was informed of its operating deficiencies and its cash flow problems. During fiscal year 1986-87 through 1989-90, the DHHS, the department, and the center's independent auditor conducted several financial and compliance audits of the center. These audits cited the center for several financial management deficiencies and for poor delivery of medical services to its patients. In particular, the center was cited for cash flow problems and for failing to promptly pay its suppliers and other health care providers. The center should have been aware of its cash flow problems since at least February 1988 when its independent auditor released his report. According to the minutes of the board meetings during fiscal year 1989-90, the center's cash flow problems were frequently reported to the board; however,

the minutes indicate that the center took few steps to improve its cash flow situation, or more importantly, to improve its operating efficiency and profitability.

### Closing of the Center

In June 1990, the federal DHHS released an audit report that criticized the center for poor fiscal management. According to the board minutes of June 27, 1990, the DHHS indicated that the center would have to terminate its senior management before it would provide the center with additional federal funds. On July 6, 1990, the board terminated the center's executive director and temporarily assigned its fiscal officer to the position of interim executive director. At this time, the board also acknowledged that the center may have to reduce its staff and the services provided to its patients.

As mentioned on Page 2 of this report, in August 1990, the board discussed filing a Chapter 11 petition for protection from creditors under the United States bankruptcy laws. However, the board decided not to file for bankruptcy but to wait for additional funding from the State and the DHHS. The center did not receive the funding it anticipated. Then, on August 27, 1990, the center's interim executive director abruptly resigned, leaving the center without any senior management personnel responsible for the administration of the center. As a result, the board decided to release the center's staff and eliminate all services except prenatal.

In October 1990, the DHHS advanced the center approximately $110,000 from its fiscal year 1991-92 federal grant. This advance allowed the center to reopen with a new staff and a predominantly new board. However, the center began to reopen without first resolving the accounting and administrative deficiencies that led to its closure. As a result, as of March 31, 1991, the center continues to have financial difficulties. (In Chapter 1 of this report, we discuss the details of the center's current financial condition.)

## Scope and Methodology

We were requested to review the financial operations of the center. In addition, we were asked to review the center's professional services contracts. To conduct the audit, we reviewed the applicable laws and regulations and the center's own Procedures and Protocol Manual of April 1979. However, we were limited in our review of the center's policies and procedures because the center's Procedures and Protocol Manual did not include policies and procedures to govern its financial operations, such as accounting and billing. During our review, although we found excerpts of financial policies and procedures the center had drafted and incorporated into its Procedures and Protocol Manual, these procedures were never approved and implemented. We also reviewed audit reports prepared by the federal DHHS, the department, the center's independent auditor, and an external audit group. Further, we reviewed the minutes of the center's board of directors' meetings from September 1989 to February 1991. We also interviewed board members and attended some of the center's board meetings.

To determine the center's sources of revenue that it received from July 1, 1989, to June 30, 1990, we reviewed the center's cash receipts register for revenues, such as public support that the center received in the form of grants from the federal DHHS and from state sources. We also reviewed revenues the center generated from its patients for all of the center's health plans. In addition, we reviewed the center's cash disbursement register for disbursements the center made for personnel services, operating expenses, and equipment.

To determine the center's effectiveness in billing promptly for health care services the center provides to patients, we reviewed the billing for reimbursement of health care services provided to patients for three of the center's health plans: Medi-Cal, Private Insurance, and Self-Pay. To determine whether the center promptly bills for its reimbursements of health care services, we reviewed more than 2,700 patient encounter forms. These were forms that were backlogged at the center on three different occasions in October 1990 and January and February 1991 for patients who had received services several months earlier. The encounter form is the document the center's clinical staff prepare and

complete for each patient. The staff enter on the form procedure codes to indicate the services that the patient receives.

To determine whether the center bills properly for all health care services it provides to its patients, we interviewed staff in the center's billing department to determine the center's process for billing Private Insurance and Self-Pay plans. However, because the center had lost its former staff responsible for Medi-Cal billings, we contacted the Electronic Data Systems (EDS), the fiscal intermediary that processes Medi-Cal claims for the Department of Health Services, to determine the process for billing for Medi-Cal reimbursements. Also, we selected a sample of 136 encounter forms of patients to whom the center provided health care services through Medi-Cal, Private Insurance, and Self-Pay plans for September and October 1989 and February, June, and October 1990. We reviewed the patient encounter forms to determine if the center's billing department prepared the billings properly. For Medi-Cal reimbursements, the center did not retain a hard copy of the magnetic tape it generates and sends to the EDS for billings; therefore, we used the EDS's return claims, which document the health care services the EDS reimbursed to the center through Medi-Cal.

To determine whether the center routinely collects amounts owed for health care services it provides to patients, we were also limited in our review because the center did not have established policies and procedures for collection actions or the necessary records available to document the center's collection activities.

To determine whether the center's expenditures for goods and services are appropriate, we selected 30 payments made to vendors during fiscal year 1989-90. We examined the selected payments to determine whether the center had authorized the purchase associated with each payment, whether the center had obtained evidence that the goods or services were received, and whether the center reviewed the vendor's invoice before it made payment. In addition, we determined whether payments to the vendors were properly authorized.

To determine the center's total amount of debt, we reviewed the center's accounting records as of June 30, 1990, and interviewed various employees of the center. In addition, we selected 20 of the center's creditors and sent them letters asking them to confirm the total amount owed to them by the center at June 30, 1990.

Because the center could not provide us with a comprehensive, auditable list of its property and equipment, we could not perform sufficient audit procedures to allow us to conclude whether the center could account for all of its property and equipment. Our audit procedures were limited to locating items purchased during fiscal year 1989-90 and locating selected items we identified through interviews with center employees.

To determine whether the center maintains adequate controls over its personnel and payroll activities, we reviewed 10 of the center's personnel files and 18 payroll transactions during fiscal year 1989-90. We examined payroll transactions to determine whether the center's controls over payroll are adequate to ensure that payroll transactions are properly processed and recorded.

To determine whether the center properly manages its professional services contracts, we reviewed the center's contracts that it had entered into for fiscal year 1989-90. To review its contract management, we looked for records of its contracts and agreements in its central files and vendor files. However, the center does not maintain these records. Therefore, we developed a list of 48 contracts for professional services to the center. The center confirmed the accuracy of our list, and we reviewed 20 of these contracts. However, because the center did not have established procedures for properly managing its contracts, we relied on the State's contracting requirements, as outlined in the State Administrative Manual, to review the center's management of its contracts.

# Chapter 1 The Martin Luther King Jr. Family Health Center Continues To Have Financial Difficulties

## Chapter Summary

Although the Martin Luther King Jr. Family Health Center (center) was able to begin to reopen in October 1990 with an advance of $110,000 on its federal grant for grant year 1991-92 (April 1, 1991, through March 31, 1992), the center continues to have financial difficulties. As a result, the center has relied on short-term loans to meet its most critical financial needs, and it has obtained an additional advance of $300,000 on its projected $670,000 federal grant for 1991-92. To receive the $300,000 advance, the center agreed to submit to the federal Department of Health and Human Services (DHHS) an operating plan and a plan to resolve its indebtedness. On March 21, 1991, the center submitted to the DHHS its Preliminary Region IX Plan, which includes the center's operating plan and an analysis of the center's current debt and the infusion of funds it needs to continue to operate through March 31, 1992. In its Preliminary Region IX Plan, the center projects that it will realize an operating loss of approximately $362,000 for the 12 months ending March 31, 1992. In addition, the center estimates that it needs the $260,000 remaining on its 1991-92 federal grant and an additional $592,000 to continue to operate through March 31, 1992. The plan suggests that the center will spend $490,000 of these funds to reduce its current debt and the remaining $362,000 will be used to cover the center's projected operating loss through March 31, 1992.

We reviewed the center's operating plan for the 12 months ending March 31, 1992, and found that the center's projected operating loss of $362,000 over the 12 months is a reasonable approximation. We also reviewed the center's estimate of its

current debt and the infusion of funds it needs to continue to operate through March 31, 1992. We found that, while the center's estimate of its debt and funding requirements is reasonable, the center's analysis understates by about $60,000 the amount of funds it should be able to generate to pay its debts. Our analysis assumes that the center will implement the necessary controls and improvements in its financial operations that we discuss in chapters 2 through 4 of this report. Unless it immediately improves its financial operations, we believe that the center will be unable to meet its revenue projections or adequately control its operating costs.

## The Center Reopened Under New Management[2]

After closing to all of its patients, except prenatal patients, in August 1990, the center established a predominately new board of directors (board) and hired a new executive director. On October 2, 1990, the center issued a press release informing the community of Richmond that it was reopening under new management and would again be providing services such as family planning, homeless outreach, and prenatal care. The center's press release also stated that the center was going to develop a plan to resolve its indebtedness, and it asked creditors to forgive the center's debt.

The center was able to begin to reopen in October 1990 primarily because the DHHS had given the center an advance of approximately $110,000 from the center's federal grant for grant year 1991-92, which covers April 1, 1991, to March 31, 1992. In addition, the center was able to borrow $24,000 from a local health care clinic.

[2] We derived some of the information presented in this section from the minutes of meetings of the center's board of directors; however, we did not attempt to validate the accuracy of the information contained in these documents.

Unfortunately, the center began to reopen without first resolving the accounting and administrative deficiencies that led to its closure in August 1990. As a result, the center was not able to properly manage its financial operations, and it once again experienced cash flow problems. In December 1990, two months after the center began to reopen, the center sought to alleviate its cash flow problems by requesting an additional $300,000 advance from its 1991-92 federal grant. However, before agreeing to make an additional advance, the DHHS required the center to comply with certain conditions. Among other conditions, the DHHS required the center to submit an operating plan that included measures designed to reduce the center's operating expenses as well as a plan to meet its debts. In addition, the DHHS stipulated that if the center could not resolve its cash flow problems by March 31, 1991, the DHHS would not provide the center with any additional funds and the center would either have to close or operate without DHHS support. The center's board responded to the DHHS offer in December 1990 and accepted the DHHS' conditions.

Also during December 1990, while the center was negotiating for an advance from the DHHS, the center had to borrow funds to meet its short-term cash flow needs. The center borrowed a total of $110,000 in December: $35,000 from a local health care center and $75,000 from Contra Costa County. Both of these loans required the center to repay the lenders immediately upon receipt of the anticipated advance from its federal grant. According to the center's executive director, the center did not receive the advance on its federal grant until early March 1991. So, in February 1991, the center again was forced to borrow. This time, the center borrowed $100,000 from a bank. By the time the center received the advance on its federal grant, at least $210,000 of the $300,000 advance was committed to repay the center's short-term loans.

To assist the center in meeting the conditions the federal DHHS had stipulated, the chief financial officer for the Department of Health Services of Contra Costa County agreed in January 1991 to provide technical assistance to the center. The chief financial officer and his staff have assisted the center with its accounting and administrative activities and, on March 21, 1991, the center and the county jointly submitted to the DHHS the center's operating plan and its plan to resolve its debt. In the remainder of this chapter, we will examine these plans.

## The Center's Projected Operating Loss for Federal Grant Year 1991-92

On March 21, 1991, the center submitted to the DHHS its Preliminary Region IX Plan, which includes the center's projected income statement for grant year 1991-92. The center projects for grant year 1991-92 that it will generate revenue of $579,212 and incur expenses of $941,354, resulting in an operating loss of $362,142, excluding federal grant revenue. Table 1 presents the center's projected income statement for April 1, 1991, to March 31, 1992. We reviewed the center's revenue and expense projections for that year, and while we believe that the center's plan understates both revenues and expenses by a small amount, the center's projected operating loss is a reasonable approximation.

**Table 1** **Martin Luther King Jr. Family Health Center**
**Projected Revenues and Expenses**
**For April 1, 1991, to March 31, 1992**

| | Center Projection as of March 21, 1991 |
|---|---|
| Revenues | |
| Grants and contracts | $ 150,962 |
| Patient revenues | 314,351 |
| Medi-Cal cost reimbursement | 113,899 |
| Total Revenues | 579,212 |
| Expenses | (941,354) |
| Income (Loss) From Operations | ($ 362,142) |

## The Center's Projected Debt and Funding Requirements

The center included in its Preliminary Region IX Plan an analysis of its current debt and the infusion of funds that it needs to continue operating from April 1, 1991, to March 31, 1992. Table 2 presents the center's analysis of its current debt and funding requirements and our analysis of the center's current debt and funding requirements. As Table 2 shows, the center estimates that it will need approximately $852,000 to continue to operate through March 31, 1992. To meet its financial needs, the center hopes to obtain a total of $300,000 from retroactive Medi-Cal reimbursements, additional long-term financing, and private grants. In addition, the center hopes to obtain the $260,000 it has left on its 1991-92 federal grant and $300,000 in additional federal and state support. We reviewed the center's estimate of its current debt and its funding requirements, and we believe that the center's estimates are reasonable. However, we believe that the center may be able to raise approximately $60,000 more than it estimated to meet its funding requirements.

**Table 2** **Martin Luther King Jr. Family Health Center**
**Projected Funding Requirements**
**As of March 31, 1991**

| | Center Projection as of March 21, 1991 | Auditor General | |
|---|---|---|---|
| | | Adjustment | Projection |
| Projected Operating Loss | | | |
| April 1991 through March 1992 | ($362,000) | | ($362,000) |
| Current Debt | | | |
| Accounts payable | (350,000) | | (350,000)[a] |
| Taxes payable | (140,000) | | (140,000)[a] |
| Total Projected Debt[b] | (852,000) | | (852,000) |
| Center Generated Funding | | | |
| Medi-Cal retroactive cost reimbursement | 100,000 | $120,000 | 220,000 |
| Additional equity financing | 100,000 | | 100,000 |
| Private grants | 100,000 | (60,000) | 40,000 |
| Net Funding Requirements | (552,000) | $ 60,000 | ($492,000) |
| Other Projected Funding[c] | | | |
| Department of Health and Human Services 330 grant | 260,000 | | |
| Additional DHHS support | 150,000 | | |
| State Support | 150,000 | | |
| Net Surplus | 8,000 | | |

[a]We did not attempt to validate the actual amount of the payables. Instead, we performed tests to determine whether these amounts appeared reasonable.

[b]Excludes potential contingent liabilities. (See page 24 for a discussion of this issue.)

[c]We did not attempt to estimate the likelihood of the center receiving these funds. (See page 24 for discussion of this issue.)

### Difference Between the Center's Projection of Its Funding Requirements and Our Projection

Our estimate, as shown in Table 2, of the center's current debt and its funding requirements is based on our analysis of the center's estimates and of other information available from the center and other sources. We only adjusted the center's estimates in those instances where we considered the center's estimates to be misstated by more than 10 percent. In the following paragraphs, we explain those instances where we did adjust the center's estimates, and we provide additional information we consider relevant to an analysis of the center's current financial position.

**Retroactive Medi-Cal Cost Reimbursement Increased by $120,000:** We increased the center's estimate of its reimbursement from the California Medical Assistance Program (Medi-Cal) cost-reimbursement program for federally qualified health centers by $120,000. In accordance with the Omnibus Budget Reconciliation Act of 1989, federally qualified health centers in California are to be reimbursed for the actual cost to the center of providing services to Medi-Cal eligible patients. The Martin Luther King Jr. Family Health Center is currently one of the health centers eligible for such cost-based reimbursement. Before the implementation of this program in April 1990, the center received reimbursement from Medi-Cal on a fee-for-service basis. However, the center is now entitled to be reimbursed for the difference between the center's actual cost for providing the service and the amount the center received for each patient visit under the fee-for-service method retroactive to April 1990.

In the Preliminary Region IX Plan, the center includes expected revenue from retroactive Medi-Cal cost reimbursement of $100,000. However, according to the director of finance of the County Department of Health Services, the center expects to negotiate this $100,000 as an advance of the total amount due. In fact, this amount represents only a portion of the total amount the center expects to receive at the end of the fiscal year. The center actually

estimates that it will receive a total of approximately $220,000 from retroactive cost-based Medi-Cal reimbursement. Based on our evaluation of past Medi-Cal reimbursement to the center, we conclude that $220,000 is a reasonable estimate of the total amount the center can expect to receive for retroactive cost-based Medi-Cal reimbursement; therefore, we included the total amount in our projection.

**Private Grants Reduced by $60,000:** We reduced the center's estimate of the amount of funds it could raise from outside parties by $60,000. The center does not currently have any written commitments of support from outside parties. Therefore, we feel the center's estimate of $100,000 is overly optimistic. However, in 1988 and 1989, the center did receive an average of approximately $40,000 from outside parties. For example, in fiscal year 1988-89, the center received more than $18,000 in community development grants and $20,000 from a private foundation. We estimate that the center can at least match its previous level of support from outside parties.

**Other Projected Funding:** The center's projections in Table 2 include the center's estimate of the amount of federal and state support it could receive. According to the center, if its operating plan is accepted by the DHHS and if it can obtain state funding of approximately $150,000, the DHHS would provide the center with the $260,000 remaining on its 1991-92 grant, as well as an additional $150,000 of federal funds. We did not attempt to estimate the likelihood of the center receiving these funds because the actual amount the center receives, if any, is contingent upon the outcome of negotiations with federal and state officials.

**Other Conditions and Contingencies:** The projections in Table 2 exclude certain liabilities of the center because neither we nor the center can determine the amount of the liabilities or when the liabilities may have to be paid. For example, three former employees have filed claims with the State Division of Labor Standards Enforcement claiming that they were not compensated for their accumulated vacation leave when they left the center. Although the amount of the claims totals more than $65,000, the amount of the final settlement and the timing of any payments to the former employees are not known. In addition, the center estimates that it owes approximately $30,000 in past due lease charges on three equipment leases. The past due lease charges are included in the center's accounts payable estimate on Table 2. However, according to the executive director, the center has negotiated a payment schedule for one lease and intends to negotiate buy-outs of the other leases and return the equipment to the lessors. The additional cost of such buy-outs, if any, is not known and, therefore, is not reflected in Table 2. Finally, Table 2 does not reflect the center's potential liability to certain health care providers under the Primary Care Case Management Program (PCCM). Neither we nor the center can determine the amount of the liability, if any, because the center has not maintained records adequate enough to develop an estimate.

The center's projections in Table 2 also do not reflect the amount the center owes on its mortgage, which is secured by a deed of trust. The center currently owes approximately $203,000 on the mortgage and is paying $2,700 per month, including interest. We also excluded the payment on the principal of this loan from Table 2 in analyzing the center's need for financial assistance because the center does not have to immediately repay this loan in full. Therefore, this loan is not as burdensome on the center as the other demands from its creditors. The center has indicated that it intends to refinance the mortgage and obtain an additional $100,000 in equity financing.

In addition to the liabilities mentioned above, Table 2 also does not reflect the center's accounts receivable except for the Medi-Cal retroactive cost reimbursement revenues discussed earlier. As we discuss in Chapter 2 of this report, we estimate that the center's accounts receivable for services it provided in December 1990 and January 1991 are approximately $107,800.

## Operating Improvements Needed To Realize Operating Plan

The remaining chapters of this report address weaknesses we found while reviewing the financial operations of the center. The preceding analysis assumes that the center will implement the necessary controls and improvements in its financial operations. However, if the center does not improve its financial operations, it cannot expect to realize the amount of revenues it has projected, and it cannot expect to maintain adequate control over its operating costs and ultimately improve its cash flow.

## Conclusion

The Martin Luther King Jr. Family Health Center continues to have financial difficulties. As a result, the center has had to borrow funds, and it has received advances of $110,000 and $300,000 on its $670,000 federal grant for grant year 1991-92. However, to receive the $300,000 advance, the center agreed to submit to the federal Department of Health and Human Service's an operating plan and a plan to resolve its indebtedness. On March 21, 1991, the center submitted to the DHHS its Preliminary Region IX Plan, which includes the center's operating plan and an analysis of the center's funding requirements. In its Preliminary Region IX Plan, the center estimated that it would need at least $852,000, including the $260,000 remaining on its 1991-92 federal grant, to continue to operate through March 31, 1992. The plan suggests that the center would spend $490,000 of these funds to reduce its current debt and the remaining $362,000 would be used to cover the center's projected operating loss for April 1, 1991, to March 31, 1992.

We reviewed the center's operating plan, including its revenue and expense projections and found that the center's projected operating loss for grant year 1991-92 is a reasonable approximation. We also reviewed the center's analysis of its current debt and its funding requirements and found that the center's analysis understates by about $60,000 the amount of funds that it may be able to generate to pay its debt. Our analysis assumes that the center will implement the necessary controls and improvements in its financial operations that we discuss in chapters 2 through 4 of this report. Moreover, unless it immediately improves its financial operations, we believe that the center will be unable to meet its revenue projections or adequately control its operating costs.

## Recommendations

To resolve its financial problems, the Martin Luther King Jr. Family Health Center should pursue all available sources of funding. In addition, the center should implement the controls and improvements described in the remainder of this report.

# Chapter 2 The Martin Luther King Jr. Family Health Center Needs To Improve Its Process In Billing and Collecting for Reimbursement of Health Care Services

## Chapter Summary

The Martin Luther King Jr. Family Health Center (center) needs to improve its billing and collecting for reimbursement of health care services. Although the Electronic Data Systems, which has contracted to process California Medical Assistance Program (Medi-Cal) claims, has provided a manual to the center that outlines procedures for billing for the reimbursement of health care services, the center does not bill for these reimbursements properly or quickly enough to meet its financial obligations. Also, it does not bill for immunizations at rates that reflect the costs for providing the service. Further, the center does not account for or retain important documents used to bill for health care services, nor does it routinely collect outstanding amounts owed for health care services it provides to patients. When the center does not bill promptly for the reimbursement of health care services it provides to patients, it experiences delays in receiving the revenue needed to meet its financial obligations. For example, the center has not billed for nearly $107,800 worth of health care services it provided to patients in December and January 1991, thus, contributing to its inability to meet its operating expenses. When the center does not bill properly, at the current rates, and does not routinely collect outstanding amounts owed for health care services it provided to patients, the center loses revenue. For example, in 81 cases, the center did not bill for patients' use of the examining and treatment room from September 1989 through October 1990; thus, the center lost approximately $1,760 in revenue. We estimate that the center lost more than $177,000 by neglecting to bill for the use of the examining and treatment room for the estimated 8,170 Medi-Cal patients it served during fiscal year 1989-90. The center has not billed for the reimbursement of

health care services properly and quickly enough because of problems with its computer system that generates billings, a lack of sufficient and trained staff to process the billings, and a lack of approved and implemented procedures to use for guidance in preparing billings.

## Background

The center provides health care services to low-income and medically underserved individuals and is reimbursed for the services on a fee-for-service basis through various health plans. However, according to the center's fiscal officer, before providing health care services to patients, the center verifies whether the patients are covered by a health plan or are able to pay for some or all of the medical services themselves. Before delivering services, the center prepares an encounter form for each patient and completes it as services are delivered. The encounter form indicates each of the health care services provided to each patient. Completed encounter forms are used by the center's billing department to determine the reimbursement that is due to the center. The center's billing staff, using procedure codes, enter the medical and laboratory services listed on the encounter forms into an automated data base. To bill for services provided to Medi-Cal patients, the center bills the Electronic Data Systems (EDS), the fiscal intermediary that processes Medi-Cal claims for the Department of Health Services, by sending a computer tape that summarizes the health care services provided to patients.

The center bills manually for its other health care plans, such as Private Insurance, for the reimbursement of health care services provided to its patients. To bill for reimbursement of Private Insurance, the billing staff manually prepare the billing using a health insurance claim form. The billing department relies on its own fee schedule to bill its various health plans. To bill Self-Pay patients, the center enters the list of services provided to its patients from the encounter forms into an automated system and generates billing statements to send to patients. According to the fiscal officer, for the Self-Pay plan, the center collects a deposit of $15 before providing services and bills the patient for the remaining cost of the services if the patient does not pay for services in full at the time of the visit.

## The Center Does Not Promptly Bill for Reimbursement of Services

Section 300-32-1 of the EDS's Inpatient/Outpatient Provider Manual states that proper and timely submission of Medi-Cal claims to the EDS for processing claims is of the highest importance and that delayed or improperly sent claims result in delayed payments to providers. In addition, the manual states that submitting claims through the use of computers is the most efficient method of billing for reimbursement of Medi-Cal services and results in improved cash flow because computers can prepare the claims for processing, enter the claims into the processing system, and pay the claims in a shorter time than if these duties were performed manually.

Although the EDS manual states that providers have up to six months from the date of services rendered to bill for the reimbursement of health care services, the center, to improve its cash flow, needs to hasten its billing process for these reimbursements. On three separate occasions during our audit, we estimated the number of patient encounter forms that listed services provided for which the center had not yet billed. On one occasion, the center had not promptly billed for 269 encounter forms for reimbursement of health care services it provided to patients through Medi-Cal from July through October 1990. The center did not bill for these services until November and December 1990. The center's delayed billing amounted to nearly $5,000 in revenue and contributed to the center's inability to help meet its financial obligations. In December 1990, the center borrowed $35,000 from a local health care center and $75,000 from Contra Costa County to meet short-term cash flow needs. On a second occasion, we found that the center had not processed quickly enough 267 encounter forms for reimbursement of health care services it provided to patients through Medi-Cal for November 1990. The center's delayed billing amounted to an estimated $5,000 in revenue. The center did not bill for these services until late January 1991. On the third occasion, as of February 22, 1991, we estimated that the center had not promptly processed approximately 2,200 encounter forms for reimbursement of health care services it provided to patients through its various health plans, such as Medi-Cal in December 1990 and January 1991 and Self-Pay and Private Insurance since August 1990. Once again,

the delayed billing contributed to the center's financial difficulties, and in February 1991, the center borrowed $100,000 from a bank, to meet payroll.

Each patient encounter typically involves services for at least three health care procedures, such as an office visit, use of an examining and treatment room, and one laboratory procedure. In a sample of 50 encounter forms we reviewed involving Medi-Cal patients, we estimate that the average amount of patient services that was reimbursable by Medi-Cal was approximately $49 per patient encounter: $22 for the office visit, $22 for the use of the examining and treatment room, and $5 for one laboratory test. Using $49 as the average amount per patient visit, we estimate that the center's billing for the reimbursement of these services should result in nearly $107,800 for the 2,200 encounter forms that had not been billed; however, the center may not be able to collect from all Self-Pay patients included in this estimate.

According to the fiscal officer, the center had not promptly billed for the reimbursement of health care services for its health plans, such as Medi-Cal, Self-Pay, and Private Insurance, because it lacks sufficient staff. The center has two positions for billing clerks in its billing department; however, from November 1990 through late March 1991, one of the billing clerks had been out on maternity leave. In addition to Medi-Cal, Self-Pay, and Private Insurance, the billing staff have other health care plans, such as Medicare, Child Health and Disability Prevention, and Family Planning for which to process billings. Further, the fiscal officer stated that from October through December 1990, the billing staff were not properly supervised in billing for reimbursement of health care services. Between November 1989 and May 1990 and between August and November 1990, the center did not have a fiscal officer. In December 1990, the center hired a fiscal officer to supervise the billing department. In January 1991, the present fiscal officer continued to reduce the backlog of patient encounter forms by submitting claims for reimbursement to Medi-Cal for patients who had received health care services in November 1990.

Not only did the center's billing department have staffing and supervision problems, but the center has several problems with its computer. According to the fiscal officer, until December 1990, the center did not have staff trained to operate its computer system, retrieve billing information that was stored in the system, and generate a magnetic tape of Medi-Cal claims to send to the EDS. The center's computer system was purchased by former staff who left with no instructions on how to operate the computer and generate billing data and tapes to submit to the EDS. Also, until December 1990, the center's billing department could not locate the desk manual for the computer for guidance in generating billing information. In addition, according to the fiscal officer, the center did not have sufficient funds to contract for computer programming services to delete information from its computer system to free up disk space. Therefore, even if the center's billing staff had been knowledgeable in the center's computer system, the computer did not have enough disk space for the staff to enter all of the center's backlog of encounter forms and generate a tape to submit to the EDS.

Further, according to the fiscal officer, the company that the center originally leased the equipment from is no longer in business, and the center was not successful in locating other counties or local companies with the same model computer and program format as the center's computer to request technical assistance. In late November and early December 1990, the center did, however, receive technical assistance from an individual to free up disk space in the computer and to generate a tape to submit to the EDS for Medi-Cal billings. Nevertheless, by February 1991, the center's computer system again became inoperable and did not allow the center to enter data or use the system to generate billings. The center's billing staff began to bill the EDS manually in February 1991 and will continue to do so until the center solves its computer problems, but, according to the fiscal officer, the center's computer needs new hardware that will cost approximately $12,000. However, as we mention in Chapter 4 of this report, the center has strained its relationship with many of its vendors, and some vendors have stopped doing business with the center because it either does not pay the vendors

or pays them late. Therefore, the vendors will not perform work for the center without advance payment for services provided. The center did, however, in March 1991, contract with a billing service to process patient encounters for the center's billing of reimbursement of health care services. On April 5, 1991, the center's billing service electronically transmitted to the EDS some claims for Medi-Cal reimbursement.

## The Center Does Not Properly Bill for Reimbursement of Services

Title 22, Sections 51501 et seq. of the California Code of Regulations outlines the procedures for billing for the reimbursement of health care services provided to Medi-Cal patients. Additionally, Sections 200-15 through 200-105 and 300-100 through 300-105 of the EDS's Inpatient/Outpatient Provider Manual provides program policies and instructions regarding billing for medical and laboratory procedures through Medi-Cal, such as billing for physician office visits, laboratory tests, and injections for immunizations. Also, Section 300-32-1 of the manual states that providers have up to six months from the date of services rendered to bill for reimbursement of health care services.

According to the center's policy, the center bills its other health plans, such as Private Insurance and Self-Pay, in the same way it bills for Medi-Cal reimbursements by using the patient encounter forms and billing for the procedures indicated on each form. Also, for the health care services the center provides, the staff use the same fee schedule to bill most of its health plans. However, in spite of the guidelines provided in the EDS provider manual, the center does not properly bill for medical and laboratory procedures it provides to patients through the Medi-Cal, Self-Pay, and Private Insurance plans.

We reviewed 136 encounter forms of patients who received health care services in September and October 1989 and February, June, and October 1990. In the 136 encounter forms, the center made various types of billing errors. For one single procedure, 81 of 90 patient encounter forms for Medi-Cal and Private Insurance, the center neglected to bill for the use of the examining and treatment room, as allowed. When the center's medical staff sees

a patient, the center can bill for the office visit and the use of the examining and treatment room where the patient is seen and examined. For example, one of the center's physician assistants saw a patient on June 5, 1990, for hypertension and pharyngitis (an inflammation of the throat) and indicated the procedures performed, such as the office visit and a laboratory test for a throat and nose culture. The center's billing staff billed Medi-Cal correctly for the procedures for a limited office visit and the laboratory test; however, it did not bill $21.66 for the use of the examining and treatment room.

Moreover, for 51 of the 136 encounter forms we reviewed, we found various types of other errors in which the center made a combined total of 121 errors in billing for reimbursement of health care services through Medi-Cal, Self-Pay, and Private Insurance health care plans. In 56 of the 121 errors, the center did not bill for all of the medical and laboratory procedures that it had performed. For example, on October 2, 1990, one of the center's physicians saw a patient for prenatal services and indicated on the encounter form the four procedures the center provided, such as the intermediate office visit, one laboratory test the center conducted for a complete urine analysis, and two laboratory tests that the center sent to an outside laboratory. The center's billing staff did not bill Medi-Cal for the intermediate office visit for $26.60 and the laboratory test they conducted for the complete urine analysis for $5.24. However, the center billed correctly for the collection and handling of the laboratory tests the center sent to an outside laboratory.

In another example, on October 9, 1989, one of the center's clinical staff saw a patient for an inflamed pelvic disorder and indicated on the encounter form the procedures provided for an intermediate office visit, an intravenous set-up, seven laboratory tests that the center conducted, and two laboratory tests that it sent to an outside laboratory. The center's billing staff billed the patient through Self-Pay correctly for the office visit and for five of the seven laboratory tests the center conducted. However, the staff did not bill the patient for the two laboratory tests they performed for a total of $26.99, the collection and handling charge of $4.17 for the laboratory tests the center sent out, or the procedure for the intravenous set-up for $36.

Further, in 65 of the 121 errors, the center made various billing errors such as not billing correctly for the procedures that were actually performed, that is, it billed for procedures that were not on the encounter forms or not allowed, procedures with the incorrect billing codes, procedures with incorrect fees, procedures that were different than those indicated on the encounter forms, but with the same fee, and procedures that had multiple combinations of billing errors. For example, a physician's assistant saw a patient on October 16, 1990, for hemorrhoids; the assistant indicated on the encounter form the procedures performed, such as an intermediate office visit, a laboratory test for a complete urine analysis, and two laboratory tests sent to an outside laboratory. The billing staff billed the patient through Self-Pay correctly for the office visit, the laboratory test they conducted, and the collection and handling for the two laboratory tests it sent out. However, the billing staff also billed for a laboratory procedure for $16.35 that was not on the patient encounter form.

In another example, the center's clinical staff saw a patient in June 1990 for vaginitis. On the patient encounter form, the center's clinical staff indicated the procedures performed, such as an intermediate office visit, three laboratory tests that the center performed, and two laboratory tests that the center sent to an outside laboratory. The center's billing staff billed the private insurance company correctly for the office visit and the laboratory tests the center conducted; however, the billing staff also billed the insurance company for one of the laboratory tests, a pap smear for $9.10 that was sent to an outside laboratory. According to the center's medical technologist, the center sends all pap smears to an outside laboratory because it does not have staff trained to perform this test. However, the center incorrectly billed for the pap smears. Further, the center did not bill for the collection and handling of the two laboratory tests it sent to an outside laboratory.

When the center does not bill for all procedures provided, it results in a loss of revenue. For example, the reimbursement rate from Medi-Cal for office visits varies in fees depending on the extent of the office visit, but the reimbursement rate from Medi-Cal for the use of the examining and treatment room is $21.66. Using this reimbursement rate for the center's other

health plans, since Medi-Cal reimbursement rates are generally lower than other plans, a conservative estimate of the revenue that the center lost is approximately $1,760 for the 81 encounter forms in our sample for Medi-Cal and Private Insurance patients in which the center neglected to bill for that procedure. More importantly, if each of the center's estimated 8,170 Medi-Cal patients used the center's services at least once during the year, and each patient's visit involved the use of the examining and treatment room with a physician visit, which the center neglected to bill for, a rough estimate of the total revenue that the center did not bill for was at least $177,000. Since, the center has up to six months to bill for procedures previously not billed, the center can still recover revenue for those procedures it neglected to bill for. In February 1991, we informed the center of its various billing errors, so it can submit revised bills.

Several factors contribute to the center not properly billing for all services it provides to patients. First, according to the fiscal officer, the center lacks staff sufficiently trained to identify and enter into the computer, or record manually, clinical procedures that should be routinely billed. Until January 1991, the center had not provided any training to its billing staff. However, in March 1991, the center held a training session with a representative from the EDS to provide training regarding Medi-Cal billings. In April 1979, the center had developed a Procedures and Protocol Manual for the billing staff to use for guidance in preparing billing documents. However, the center never approved and implemented the procedures contained in the desk manual. Further, according to the fiscal officer, the center could not find documentation to explain why the center did not bill for the use of the examining and treatment room. According to staff persons who were formerly employed with the center, the center did not bill for the procedure because it did not want to strain the budgets of the low-income population it served. Also, the center's patient encounter forms do not have the procedure code for the examining and treatment room printed on them; therefore, the billing staff would not be aware that the procedure is an allowable charge.

## The Center Does Not Bill for Immunizations at Appropriate Rates

The center has an established fee schedule for medical and laboratory procedures it performs to bill for reimbursements of health care services it provides to patients. For reimbursements of immunizations through Medi-Cal, Section 300-103-1 through Section 300-103-2 of the EDS's Inpatient/Outpatient Provider Manual outlines the injections, including immunizations, that providers such as the center can bill through Medi-Cal. Additionally, the manual states that the injection codes for Medi-Cal reimbursement include the cost to administer the immunization and the current cost of the medication. However, the center does not bill for reimbursement of immunizations it provides to patients through Medi-Cal, Self-Pay, or Private Insurance plans at a rate that reflects the actual costs of providing care.

In our review of encounter forms of patients who received health care services, we found four instances through Self-Pay and Private Insurance plans in which the center provided immunizations to both children and adults at a fee of only $2. In reviewing the center's established fee schedule, which includes 21 types of immunizations the center provides, the center charges only $2 for the 21 immunizations it provides to both children and adults. According to the center's nursing director, who administers immunization, a fee of $2 does not reflect the cost for the center to provide this service. When the center established the $2 fee, the fee was intended to cover an administrative fee for providing the immunizations since the center gets the children's vaccines free from Contra Costa County.

Even though the center receives the children's vaccines for free, it incurs other costs associated with providing immunization that exceed $2. According to the nursing director, for each patient, the center is required to open a medical record file that costs $5.25. Also, it purchases syringes and needles for the injections, accounts for the supply of vaccine the county provides to the center, obtains and completes a consent form to administer the vaccine, and monitors the patient for the immunizations before the patient leaves the center to ensure that the patient does not develop an allergic reaction. The nursing director estimates that the minimum cost to administer the immunizations to children and adults is $15 per immunization.

More importantly, according to the nursing director, when the county has a limited supply of vaccine for children and is unable to provide the necessary medicine to the center, the center has to purchase the vaccine itself to provide the immunizations to the children to ensure adherence to the children's immunization schedule. For example, the Measles, Mumps, and Rubella vaccine costs $23 per injection and the Poliovirus Vaccine Live Oral Trivalent Orimunt vaccine costs $21.35 per dose.

For the same immunizations that the center provides, Medi-Cal allows a reimbursement rate of an average of $14. However, according to the nursing director, in October 1985, the center revised 8 of its immunizations to reflect a fee increase. However, the center never implemented this fee increase and still charges $2 for immunizations costs for providing the service to children and adults. Because the center does not periodically update its fee schedule so that the fees charged reflect the cost of providing the medical service, it is more difficult for the center to cover its operating costs.

## The Center Does Not Account for or Retain Important Billing Documents

The center does not properly account for important documents used for the billing and reimbursement of health care services provided to patients through Medi-Cal, Self-Pay, and Private Insurance plans. Specifically, the center cannot account for encounter forms of patients seen on a given day nor does it file in any reasonable order encounter forms for patients receiving services on a specific date.

According to the draft procedures in the Procedures and Protocol Manual used for the billing department, the billing clerk should issue patient encounter forms to the clinical staff each day and annotate in a log the number of encounter forms that were issued. After the clinical staff see the patients and complete the encounter forms, the completed forms should be returned to the billing department, and the billing staff should reconcile whether the encounter forms have all been returned. However, according to the fiscal officer, the center does not assign a specific set of

encounter forms to the clinical staff by using the sequential numbers printed on the forms nor does it account for the encounter forms it uses daily. Moreover, the center's billing staff do not enter information from the encounter forms into the computer in any systematic order to account for each day of services provided. Further, after the staff enter the data into the computer and prepare the billings, the staff put the encounter forms into a box labeled with the month and year of processing instead of filing the forms by day.

The center may be losing revenue when it cannot account for and does not bill for all encounter forms of patients seen in a given day. For example, according to the fiscal officer, the center cannot account for two days of encounter forms of patients seen in November 1990. The center sees approximately 51 patients per day; we estimate that at $49 per encounter for the 102 encounter forms lost for two days, the center lost approximately $5,300. Also, when the center cannot locate the encounter forms for a specific day, it cannot double-check its computer entries to ensure that all charges for services provided are accurately entered and billed.

The center has not accounted for and maintained encounter forms in any reasonable order because, in part, it never implemented procedures it developed in the April 1979 Procedures and Protocol Manual. The procedures were to have guided billing department staff on how to account for and file the encounter forms of patients seen on various dates.

In addition, the center does not retain a copy of the computer tape that it submits to the EDS for Medi-Cal billings. When the EDS returns the tape to the center, the billing staff reuse the tape to generate new billings without printing out the data on the tape before reusing it. As a result, the center cannot double-check those Medi-Cal billings that it has already sent to the EDS for reimbursement. For example, as we mentioned on page 28 of this report, we identified several instances in which the center did not bill for all medical and laboratory procedures performed. However, without the tape or a copy of the data on the tape, the center may not be able to determine whether it, in fact, billed for all services appropriately.

## The Center Does Not Routinely Collect for Outstanding Amounts Owed for Services

Good business practices dictate that the center should make every effort to collect for services it provides to individuals either by seeking reimbursement from the patient's health plan or payment from the patient. Similarly, although the center is not required to follow state procedures, Section 8710.1 of the State Administrative Manual provides state agencies with procedures for collecting accounts receivable and ensuring prompt follow-up when payment is not received that would benefit the center if followed. The procedures provide for locating the debtor when the address is unknown by requesting the person's forwarding address from the U.S. Postal Service. Once the address of the debtor is known, the accounting office should send a sequence of three collection letters. Further, agencies may consider contracting with an outside collection agency when the three collection letters have been sent at 30-day intervals requesting payment and no payment has been received.

According to the fiscal officer, since August 1990, the center has not sent initial billing statements to Self-Pay and Private Insurance patients informing them of the amounts they owe to the center. The center generates the billing statements to Self-Pay patients through its computer system while it manually bills for private insurance. However, because of the staff's problems with the computer, as mentioned on page 27 of this report, the center has not generated the billing statements.

Also, during our review, the center could provide no evidence to show that the center routinely collected from September 1989 to December 1990 for balances for services it has provided to patients. The center could provide only two documents that showed it had attempted some collection actions since July 1989. In July and August 1989, the center used a collection bureau to conduct actions demanding and, in some cases, collecting payments from patients.

According to the fiscal officer, the center does not routinely collect for medical services it provided to patients through Self-Pay and Private Insurance plans because it does not have established procedures for sending delinquent statements to patients and following up with collection actions for overdue

balances. In December 1990, however, the center sent the first in a series of collection letters to Self-Pay patients who had outstanding balances that were less than $15 and were no more than 160-days old.

Additionally, the center does not always collect the $15 deposit it is supposed to be collecting from Self-Pay patients before providing services to the patients. In our review of 50 encounter forms of patients using Self-Pay in September and October 1989 and February, June, and October 1990, the center did not collect 8 of 44 deposits required from patients before it provided health care services.

According to the fiscal officer, the center did not always collect the deposits required from patients with Self-Pay because of an administrative decision that the center sometimes makes. If patients arrive without the deposit and cannot pay it at that time, the center makes a decision on a case-by-case basis to provide services to the patient and bill the patient for the unpaid deposit in addition to the other services the center provided. When the center does not routinely collect for health care services it has provided to patients, it results in a loss of revenue to the center.

## Conclusion

The Martin Luther King Jr. Family Health Center needs to improve its billing and collecting for reimbursement of health care services. The center does not bill promptly and properly for reimbursement of health care services, nor does it bill for immunizations at rates that reflect the cost for providing the service. Additionally, the center does not account for or retain important documents used to bill for the reimbursement of health care services. Further, the center does not routinely collect outstanding amounts owed for health care services it provides to patients. As a result of not billing quickly enough, the center is delaying the receipt of nearly $107,800 in revenue that would help the center meet its financial obligations. Also, because the center did not bill properly for the reimbursement of health care services for the 81 encounter forms we reviewed, the center lost

approximately $1,760 because it neglected to bill for patients' use of the examining and treatment room. The center has not billed for the reimbursement of health care services it provides to patients properly and quickly enough because of problems with the computer system it uses to generate billings, a lack of sufficient and trained staff to process the billings, and a lack of approved and implemented policies and procedures to use for guidance in preparing billings. In December 1990, however, the center hired a new fiscal officer to supervise the billing department. In January 1991, the fiscal officer continued to reduce the backlog of patient encounter forms by submitting claims for reimbursement to Medi-Cal for patients who had received health care services in November 1990.

**Recommendations**

To ensure that the Martin Luther King Jr. Family Health Center promptly and properly bills for the reimbursement of health care services it provides to patients, its board of directors should ensure that the center takes the following steps:

- Immediately take steps to eliminate the backlog of encounter forms that have not been billed;
- Continue to provide supervision to staff in the billing department. The center should continue to have the Electronic Data System provide training to the center's staff in the proper processing of encounter forms for Medi-Cal patients;
- Once the center generates sufficient revenue by catching up with its billings, it should pay for the service contract to repair its computer system or implement an alternative billing system;
- Review its encounter forms from October 1990 that it submitted for reimbursement, and bill for the procedures that were not previously billed, such as the procedure for the use of the examining and treatment room;

- Review and revise its standard encounter form to ensure that the form lists all procedures the center provides to patients; and

- Review the billing procedures it drafted in April 1979, and update and implement them to guide the billing staff.

To ensure that the center bills for immunizations at rates that reflect the costs for providing the service, the board should ensure that the center reviews and revises the present fee schedule for immunizations and implements the updated fees.

To ensure that the center accounts for and maintains important billing documents, the board should ensure that the center takes the following steps:

- Review the billing procedures it developed in April 1979, and update and implement them to guide staff on how to account for, file, and maintain patient encounter forms each day; and

- Retain a copy of the billings it submits to the EDS for reimbursement from Medi-Cal.

To ensure that the center routinely collects outstanding amounts owed for health care services it has provided to patients, the board should ensure that the center takes the following steps:

- Implement a reliable system to generate billings and collection statements to send to patients; and

- Implement procedures for conducting collection actions from third-party insurance providers whose customers have been served by the center.

# Chapter 3 The Martin Luther King Jr. Family Health Center Needs To Improve Its Controls Over Its Professional Services Contracts and Its Purchasing and Cash Disbursements Operations

## Chapter Summary

The Martin Luther King Jr. Family Health Center (center) needs to improve its controls over its professional services contracts and its purchasing and cash disbursements operations. For example, for its professional services contracts, the center did not obtain appropriate documentation, pay contractors according to the terms specified, amend contracts to reflect changes or modifications, seek competition before awarding contracts, or properly write up the terms of its contractual agreements. For example, during fiscal year 1989-90, in one instance of not obtaining appropriate documentation, the center entered into a contract with a marketing representative to enroll individuals into the Primary Care Case Management (PCCM) program. The center paid the representative more than $26,000 although we could find no evidence that the names of all the individuals the representative enrolled in the program had been provided, as required by the contract.

In addition, for its purchasing and cash disbursements, the center has not followed sound internal controls to ensure that purchases and cash disbursements are authorized and that disbursements are made only for goods and services received. As a result, the center may have paid for unnecessary goods and services and for goods and services it did not receive.

## The Center Did Not Properly Manage Its Professional Services Contracts

Although the center is not a state agency and is, therefore, not subject to state contracting requirements, we used the State's contracting requirements as a comprehensive set of procedures that provide guidance for managing contracts. For example, Section 1200 et seq. of the State Administrative Manual provides state agencies with procedures that include writing up all contractual agreements on standard contract forms, seeking competition before awarding a contract, entering into a valid contract before making payments to the contractor, obtaining approvals and appropriate documentation necessary for payment, and amending contracts to reflect changes or modifications. Also, Section 8400 et seq. provides guidelines for disbursing payments to contractors. Further, Section 12511 requires state agencies to have contract managers who possess demonstrated skills in contract administration, including knowledge of the State's contract requirements, competence in drafting contracts, and the ability to manage and monitor contractor performance. Although the center's policy allows for it to contract for certain services it cannot adequately perform itself, the center does not have a set of established procedures, such as the State's, to properly manage its professional services contracts.

During fiscal year 1989-90, the center entered into 48 contracts for professional services. In our review of a sample of 20 contracts that the center entered into, we found deficiencies in the center's management of these contracts.

### Obtaining Appropriate Documentation

In 9 of the 20 contracts we reviewed, the center paid the contractor without obtaining proper documentation as to what the center was paying for before paying the contractor. For example, as part of the PCCM program, the center contracted for the services of a marketing representative to enroll individuals into the program. The contract terms provided for a base salary of $2,000 per month and a commission of $18 for each individual whom the marketing representative enrolled into the program. In seeking payment, the contractor specified in the contract that the contractor would provide the names of each of the individuals enrolled in the

program. However, the center paid the marketing representative commissions of more than $26,000 although we could find no evidence that the names of each of the individuals the representative enrolled in the program had been provided, as required by the contract.

On another occasion, a physician provided physician services to the center in June and July 1990 through a physician registry service. The center paid the physician a total of $5,100 at $300 per day without obtaining any documentation. Such documentation could be a time sheet to show that the physician had worked the days the center had paid the physician. When the center does not obtain appropriate documentation before it makes payments to contractors, it cannot ensure that it pays for services actually performed.

### Paying According to the Terms Specified

In 6 of the 20 contracts we reviewed, the center did not pay the contractor according to the terms of the contract. For example, the center entered into a contract from June 1989 through June 1990 for janitorial services for its building. The payments specified in the contract were $1,112.10 a month and a onetime cleanup fee of $515; however, the center paid the contractor $12,101 in payments for the period instead of $11,636, a difference of at least $465 more than the terms specified in the contract, excluding late charges. The center could not provide us an explanation for the payments exceeding the contract.

In 4 of 6 contracts, the center did not pay the contractor according to the terms specified because it did not amend the contracts properly to reflect changes. For example, from June 1985 through December 1985, the center contracted with a corporation to provide mental health services. One of the clauses in the contract provided for automatic renewal of the contract, yet during fiscal years 1989-90 and 1990-91, the center paid the corporation a higher salary than the one specified in the contract without any evidence that the center amended the contract to reflect the change.

On another occasion, the center contracted with an individual from July 1989 through July 1990 to provide physician services for $3,820 per month or $1,815.50 biweekly. However, the center paid the contractor $2,065.65 biweekly, a difference of $250, for 13 of 33 payments the physician was paid, resulting in a total difference of $3,250. Further, from January to June 1990, the center, without amending the contract, also paid the contractor by the hour instead of by the base pay specified. Specifically, the center paid the contractor $35 per hour, in addition to paying him for providing on-call services after clinic hours. The $35 per hour rate was not specified in the contract. Furthermore, the center could not provide justification for the differences in the amount paid to the contractor. When the center does not pay contractors according to the terms specified in the contracts, it makes unauthorized disbursements and pays for excessive expenditures.

### Seeking Competition Before Entering Contracts

For all 20 contracts we reviewed, we could find no evidence in the files that the center sought competition before awarding the contracts or provided justifications for the contracts awarded as sole source. For example, the center entered into a contract with a firm from April 1990 through April 1991 to provide planning and program development services to the center. We found no evidence that the center sought competition to ensure that it was obtaining the best price for the planning and program development services. When the center does not seek competition before it enters into contracts, it cannot ensure that it is obtaining the best price for the services it needs.

### Providing Written Contracts

The center did not always provide a written contract or have contractors sign their contracts. Although, the center has a standard form that it uses to enter into and execute contracts, in 6 of the 20 contracts we reviewed, the center did not either write

a contract, use the standard form, or have the contractor sign the contract. For example, the center entered into an agreement with a local pharmacy in February 1990 to provide pharmacy services to patients for one of the center's health plans. However, the center did not write an actual contract. Instead, the center used a letter as its contract or agreement and sent the letter to the pharmacy. The assistant director signed it, thanking the pharmacy for agreeing to provide the center with services. In the letter, the center did not specify all necessary conditions the center generally includes in its contracts, such as a complete scope of services under the contract, the full period of agreement, amount of compensation and method of payment, and other terms and conditions, as outlined in the standard agreement. By not providing written contracts to contractors, the center cannot ensure that the contractor complies with the conditions and terms agreed upon.

### Making Payments Before Signing Contracts

In 5 of the 20 contracts we reviewed, the center began making payments to the contractors before the executive director's approval of the contracts. For example, beginning on April 1, 1990, the center contracted with an individual to assist the center in the operation of the center's computer for billing and accounting, yet the center began making payments to the contractor in February 1990, before both parties signed the contract. When the center makes payments before it enters into contracts, it is less able to ensure that the contractor will satisfactorily provide the services that the center expects from the contractor.

### Maintaining a Record of Contracts

The center does not maintain a summary record of the contracts that it has entered into or the amount of its obligations under these contracts. For example, the center could not provide summary information on the professional service contracts or the amount of contract obligations it had for fiscal year 1989-90. Instead, we developed such a list and requested that the center confirm the accuracy of our list. As a result of this weakness, the center's ability to monitor its contracts or determine the total amount of its obligations is hampered.

The center did not properly manage its professional service contracts because it did not have established procedures for appropriate contract management, such as establishing guidelines for documents necessary for payment, paying contractors according to the terms specified, amending contracts to reflect changes, and entering into and executing contracts.

## The Center Did Not Always Ensure That Disbursements Were Documented and Authorized

The center needs to strengthen its control over purchases of medical and office supplies, services, and equipment to ensure that the purchases are documented and that appropriate personnel approve the purchases before they are made. In our review of 30 payments for goods and services the center purchased during fiscal year 1989-90, we found 8 cases where the center did not adequately document or formally approve the purchases before they were made. As a result, the center paid its vendors more than $8,600 for goods and services that may not have been absolutely necessary for the center's operation. In all 8 cases, the center did not ensure that its employees prepared purchase documents to document the items purchased and to obtain management approval of the purchases before they were made.

Moreover, during July and August 1990, a former interim executive director paid himself more than $16,700 from the center's checking and savings accounts. According to the board of directors (board), these payments exceeded any compensation that the center owed him. The former interim executive director was able to make these payments to himself because the board had authorized him to sign checks of up to $4,000 each without obtaining a second signature. After the former interim executive director made the payments to himself, the board notified him that he could no longer sign checks in an amount greater than $500 and that any checks over that amount would have to be countersigned by an authorized board member. On August 27, 1990, the former interim executive director abruptly resigned. Then, on August 31, 1990, the board sent a letter to the former interim executive director demanding that he return the payments he made to himself. However, as of the end of our audit work, the board had not received any repayment.

Sound internal controls dictate that disbursements should not be made unless supported by authorized purchase documents. Further, employees who initiate purchases should not do so until the purchases have been properly approved. The center developed purchasing procedures in 1979 and placed them in its procedures manual. However, no evidence exists that the center ever implemented the procedures. Finally, sound internal controls dictate that two signatures should be required on all checks above a reasonable dollar limit and that individuals should not be allowed to issue payments to themselves.

## The Center Does Not Ensure That Vendor Invoices Represent Goods or Services That Have Been Received Before It Pays the Invoices

The center needs to strengthen its control over disbursements to ensure that it is paying only for goods and services it has received. Specifically, for 8 of the 30 disbursements that we reviewed, the center did not count, inspect, or otherwise determine whether it had received the goods or services it was paying for. As a result, the center cannot be sure whether it received more than $9,600 in goods and services for which it had made payment. The center does not document its receipt of goods or services because it has not implemented any procedures to require such documentation.

In addition, the center has not adequately reviewed vendor invoices to ensure that amounts billed by vendors are appropriate before paying the vendors. For example, during fiscal year 1989-90, the center sponsored a group health insurance plan for its employees. Each month, the center received an invoice listing the employees enrolled in the plan. For the three invoices that we reviewed, the center paid at least $1,350 for seven employees who no longer worked at the center and, therefore, should not have been covered by the plan. In one case, the center continued to insure a former employee under its group health plan for at least five months after the employee had resigned. Similarly, during fiscal year 1989-90, the center paid more than $3,500 for automobile insurance on two vehicles. The center continued to fully insure the two vehicles even though it cannot locate one of the vehicles. The center paid these unnecessary charges because no one at the center reviewed the invoices before

paying them; therefore, no one questioned their reasonableness. The center has no written procedures that require invoices to be reviewed by knowledgeable personnel before the invoices are paid.

Sound internal controls dictate that all vendor invoices be reviewed to ensure that the vendors' charges are appropriate before the vendors are paid. For example, the State Administrative Manual, Section 8422.1, requires state agencies to determine that invoiced items have been received and that invoices comply with the provisions of the purchase orders before the agencies can pay vendors.

## Conclusion

The Martin Luther King Jr. Family Health Center needs to improve its controls over its professional services contracts and its purchasing and cash disbursements operations. For example, for its professional services contracts, the center did not pay contractors according to the terms specified, amend the contracts to reflect changes or modifications, seek competition, or write up the terms of its contractual agreements. The contracting weaknesses resulted because the center lacked established procedures for appropriate contract management. In addition, for its purchasing and cash disbursements, the center has not followed sound internal controls to ensure that purchases and cash disbursements are authorized and that disbursements are made only for goods and services received. As a result, the center may have paid for unnecessary goods and services and for goods and services it did not receive.

## Recommendations

To ensure that the Martin Luther King Jr. Family Health Center properly manages its professional services contracts, the board of directors should ensure that the center implements procedures for appropriate contract management. These procedures should specify that all contractual agreements be written up using standard contract forms, the center seek competition before awarding contracts, obtain appropriate documentation before paying

contracts, pay contracts according to the terms specified in the contract, amend contracts to reflect changes, not make payments before entering into a contract, and maintain a summary record of contracts.

To ensure that the center adequately controls its purchasing and cash disbursements, the board should ensure that the center takes the following steps:

- Implement procedures to ensure that it prepares purchase documents and that senior management approves all purchases before they are made;
- Implement procedures to ensure that it makes cash disbursements only with the board's approval; and
- Implement procedures to ensure that vendors are not paid until center staff determine that the vendor charges are appropriate and necessary and that the goods or services have been received.

# Chapter 4 The Martin Luther King Jr. Family Health Center Needs To Improve Its Controls Over Its Accounting and Administrative Operations

## Chapter Summary

The Martin Luther King Jr. Family Health Center (center) has not maintained accounting records adequately enough to monitor amounts owed to vendors and other creditors. As a result, as of June 30, 1990, the center had understated its liabilities by at least $100,000. In addition, the center has not maintained adequate records or established adequate safeguards to protect its property and equipment. As a result, the center has lost some property and equipment, including a 1975 Chevrolet sedan. Further, the center has not maintained adequate controls over its payroll activities. Specifically, the center has not always ensured that services were received before it issued payroll checks. Moreover, the center did not promptly remit at least $97,000 of federal payroll taxes for 1989, and it has not yet remitted at least $100,000 of federal and state payroll taxes for January through June 1990. Finally, the center has not separated incompatible duties within its accounting office. Failure to adequately separate incompatible duties within an organization can allow individuals to perpetrate and conceal fraudulent acts.

## The Center Does Not Adequately Record or Monitor Its Liabilities

The center does not maintain accounting records adequately enough to properly monitor or manage its liabilities to vendors and other creditors. Specifically, the center does not consistently or accurately record its liabilities in its accounting records. For example, we found that the center does not keep accurate records of its accounts payable or its unpaid payroll taxes. As a result, the center does not always know the total amount of its debt.

### Inaccurate Accounts Payable

Sound internal controls dictate that all liabilities be recorded and that a list of the accounts payable be maintained with sufficient detail to identify the vendor, the amount owed, and how long the amount has been unpaid. For example, state agencies commonly maintain a subsidiary list of accounts payable. In addition, the State Administrative Manual, Sections 7800 and 7823, requires the agencies that maintain a subsidiary listing to reconcile their subsidiary listings to their general ledger monthly.

The center does not maintain accurate or complete records of amounts owed to its vendors. According to the center's accounts payable account in its general ledger, the center owed more than $182,000 to its vendors as of June 30, 1990. However, the center's detailed list of its accounts payable, which showed the amount the center owed to each vendor and how long each amount had remained unpaid, indicated that the center owed more than $232,000 to its vendors; approximately $50,000 more than the center had recorded in its general ledger. Further, based on our communications directly with some of the center's vendors, we found that the accounts on the center's detailed list of accounts payable were understated by at least $24,000. This understatement made the total accounts payable at June 30, 1990, at least $256,000, approximately $74,000 (41 percent) more than the $182,000 the center had recorded in its general ledger.

In addition, we noted that the center does not routinely prepare a detailed list of its accounts payable. As of the completion of our audit work, the center has only partially updated its detailed list of accounts payable since mid-November 1990. The center does not maintain adequate information about its accounts payable because it has not developed procedures to ensure that unpaid vendor invoices are retained and filed in an organized manner. In addition, the center has not developed procedures to accumulate the amount of its unpaid invoices.

Because of the center's incomplete accounts payable records and its lack of funds, the center has not always paid its vendors promptly. As a result, the center has strained its relationship with

many of its vendors. Some vendors were so frustrated over the center's late payments or nonpayments that they stopped doing business with the center and directed their collection agents or attorneys to proceed with collection actions. Other vendors began to require cash in advance before they would do business with the center. For example, one vendor would not perform repair work on some laboratory equipment unless the center paid $1,600 in advance. In addition, the center's failure to promptly pay its liabilities caused it to incur late payment fees and penalties. For example, in July 1989, the center paid $3,985 in past due lease charges, which included $305 in late fees.

### Inaccurate Record of Payroll Taxes

Sound internal controls dictate that accounting procedures be developed to compute liabilities, including payroll taxes. In addition, good internal controls dictate that all liabilities be promptly recorded. However, the center did not keep an accurate record of its unpaid payroll taxes. At June 30, 1990, the center's taxes payable account had a negative balance of approximately $12,700. However, in March 1991, the center completed a detailed analysis of its unpaid payroll taxes and found that as of June 30, 1990, it actually owed at least $100,000. The center did not accurately record its liability for unpaid payroll taxes because its accounting personnel did not have adequate training on how to compute the liability, because it did not have any written procedures to compute and record the liability, and because it did not have a fiscal officer during most of fiscal year 1989-90 to supervise accounting activities.

## The Center Does Not Maintain Adequate Control Over Its Property and Equipment

Sound internal controls dictate that detailed records should be kept of all equipment acquisitions and that all equipment be tagged or otherwise marked for easy identification. For example, the State Administrative Manual, Section 8650, requires state agencies to keep track of property information on an automated property accounting system or on property record cards. The information the agencies are required to maintain for each item

includes the date acquired, a property description, an identification number, the cost or other basis of valuation, and the rate of depreciation. In addition, the State Administrative Manual, Section 8651, requires state agencies to tag all state equipment when practical.

The center has not maintained adequate records or established adequate controls to protect its property and equipment from loss or misuse. The center's property and equipment consists of medical equipment, office furniture and equipment, computer equipment, two automobiles, and land and a building that the center purchased from the City of Richmond for $1. According to the center's accounting records, the center spent more than $391,000 to purchase its medical equipment, office furniture and equipment, computer equipment, and automobiles. However, the center has not kept detailed records of the specific items of equipment it has purchased. In addition, the center has not tagged or otherwise marked its equipment to provide for positive identification. Because the center has no detailed listing of its equipment, it was impossible for us to account for the equipment that should be on the center's premises. The center's executive director stated that she has been unable to locate the center's 1975 Chevrolet sedan or 11 of 14 electronic pagers that the center leased during fiscal year 1989-90. The center has not maintained adequate records of its property and equipment or tagged its equipment because it has not developed any procedures to provide such controls.

## The Center Does Not Maintain Adequate Control Over Its Payroll Activities

The center needs to improve its controls over its processing of payroll transactions and its maintenance of employee leave records. We found that the center does not ensure that it has received services before it issues payroll checks or that it has recorded vacation and sick leave benefits for each employee. In addition, the center does not always promptly remit its payroll taxes to the appropriate tax agencies. As a result, the center may have paid for services it did not receive and has incurred penalties and interest for failing to remit payroll taxes promptly.

Specifically, the center did not always obtain sufficient evidence that services were performed before it issued payroll checks even though the center's personnel manual required all payroll payments to be based on completed and properly approved time sheets. For example, we reviewed 18 payroll transactions, but we could not locate employee time sheets for 8 of the 18 transactions. Therefore, we could review time sheets for only 10 of the transactions. Furthermore, for 4 of the 10 transactions, the employees' supervisors did not certify the employees' time sheets as being accurate. If the center issues its payroll checks without adequate documentation or certification that services were performed, the center could pay for services it has not received.

In addition, in 5 of the 10 payroll transactions we reviewed, the center did not record on the employees' leave cards the number of hours of sick leave the employees earned. As a result, employee leave records were not accurate, and the center could not determine the number of hours of leave available for its employees. Moreover, the center did not always record on the employees' leave cards the number of hours of vacation leave the employees earned. For example, it could not determine the amount of compensation for accumulated vacation leave it owed to some of its employees when they resigned from the center. Three former employees have filed claims with the state Division of Labor Standards Enforcement alleging that they were not fully compensated for their accumulated vacation leave when they left the center. These three claims total more than $65,000.

Finally, we found that during fiscal year 1989-90, although the center withheld payroll taxes and deductions for retirement plans from its employees' paychecks, the center did not promptly remit the withholdings and deductions to the appropriate organizations. For example, for July 1989 through December 1989, the center did not begin to remit at least $97,000 in federal payroll taxes until April 1990. As a result, the center owes an additional $3,338 in interest. In addition, as of the completion of our audit work, the center has not remitted at least $100,000 of state and federal payroll taxes for January through June 1990. The center has a history of not promptly remitting payroll taxes. During our review, we found that the center did not begin to remit more than

$22,100 to the State's Employment Development Department for payroll taxes incurred between October 1984 and December 1987 until January 1990. The $22,100 incurred by the center included more than $13,200 for penalties and interest.

The center made payments to its employees without adequate documentation of services performed, and it failed to properly record vacation and sick leave benefits because it did not follow its own procedures. The center's personnel manual required all payroll payments to be based on completed and properly approved time sheets. In addition, the personnel manual required that personnel records contain documentation of leave records. Finally, we found that the center did not promptly remit its payroll withholding taxes because it has not developed procedures to ensure that the amount of taxes is properly computed and because it did not always have sufficient funds to make the remittances.

## The Center Has Not Adequately Separated Duties

Sound internal controls require an adequate separation of incompatible duties. However, the center has not ensured an adequate separation of duties related to its billing and cash receipts activities, its purchasing and cash disbursement activities, and its payroll activities.

Sound internal controls require that the employees who handle billing activities should not also handle cash receipts. However, the center's billing clerk collects cash receipts, prepares patient billings, and enters charges and receipts into the patients' accounts. Without adequate separation of these duties, a billing clerk could divert cash for personal use and conceal the theft in the patient accounting records.

In addition, sound internal controls require that the employees who handle checks should not also receive incoming merchandise or enter transactions into the disbursement records. Moreover, an employee responsible for reconciling bank accounts should not also be responsible for cash receipt and cash disbursement duties. However, the center's bookkeeper has performed all of these

duties. We observed that the bookkeeper processes vendor invoices, prepares checks, receives some incoming merchandise, enters checks into the cash disbursement records, maintains the general ledger, prepares and makes deposits, and reconciles the bank accounts. Without adequate separation of cash disbursement duties, a bookkeeper has the opportunity to conceal a fraudulent act. For example, a check could be written and not recorded in the cash disbursement register; later, the theft could be concealed when the bank accounts are reconciled.

Finally, sound internal controls require that employees who process payroll documents, such as reports of appointment and attendance reports, should not also handle payroll checks. However, according to the fiscal officer, the bookkeeper maintains the employee roster, handles personnel documents such as reports of appointment, handles the payroll checks, and as mentioned earlier, maintains the general ledger and reconciles the bank accounts. Without adequate separation of payroll processing and cash handling duties, a bookkeeper could place a fictitious employee on the payroll roster, collect the check issued to the fictitious employee, and later conceal the theft when the bank accounts are reconciled.

The employees described above have incompatible duties primarily because the center has centralized many accounting and administrative functions among too few employees. The center could have separated some of these duties by having employees from outside the accounting office perform selected functions--for example, the receptionist could collect cash receipts. Another employee outside the accounting office could have been responsible for performing the bank reconciliations.

**Conclusion**

The Martin Luther King Jr. Family Health Center has not maintained accounting records adequately enough to monitor amounts owed to vendors and other creditors. As a result, as of June 30, 1990, the center had understated its liabilities by at least $100,000. In addition, the center has not maintained adequate records or established adequate safeguards to protect its property and equipment. As a result, the center has lost some property and equipment, including a 1975 Chevrolet sedan. Further, the center has not maintained adequate controls over its payroll activities. Specifically, the center has not always ensured that services were received before it issued payroll checks, and it did not promptly remit at least $97,000 of federal payroll taxes for 1989 and it has not remitted at least $100,000 of state and federal payroll taxes for January through June 1990. Finally, the center has not separated incompatible duties within its accounting office. Failure to adequately separate incompatible duties within an organization can allow individuals to perpetrate and conceal a fraudulent act.

**Recommendations**

To ensure that the Martin Luther King Jr. Family Health Center adequately records, monitors, and manages its liabilities, the board of directors should ensure that the center takes the following actions:

- Implement procedures to ensure that it maintains sufficient information on its liabilities and routinely computes and records the amount of its liabilities; and

- Provide training for employees who maintain liability records and provide adequate supervision over these employees;

To improve the center's control over its property and equipment, the board should ensure that the center implements procedures to ensure that its property and equipment acquisitions and dispositions are accurately recorded with sufficient detail to provide accountability and control and that each item is tagged or marked for identification purposes.

To ensure that the center maintains adequate personnel and payroll documentation and that it pays only for services received, the board should ensure that the center takes the following actions:

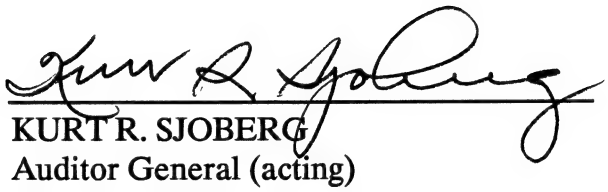
- Adhere to its procedures by issuing payroll checks only upon verification that services have been received and by recording vacation and sick leave accumulation and usage; and

- Implement procedures to ensure that payroll expenses are properly recorded and that payroll withholdings and deductions are promptly remitted to the appropriate organization.

To ensure functions are assigned so that no single individual is in a position to both perpetrate and conceal errors or irregularities in the normal course of his duties, the board should ensure that the center establishes policies to provide an adequate separation of duties within all of its accounting and administrative activities.

We conducted this review under the authority vested in the auditor general by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
Auditor General (acting)

Date: April 15, 1991

Staff: Steven M. Hendrickson, Audit Manager
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## Appendix A-1 Comparative Statement of Revenue and Expenses Fiscal Year 1985-86 Through 1988-89

| | 1988-89 | 1987-88 | 1986-87 | 1985-86 |
|---|---|---|---|---|
| Revenue | | | | |
| Public Support | | | | |
| Federal government | $ 810,040 | $ 910,371 | $ 551,420 | $ 544,896 |
| State of California | 46,531 | 33,848 | 29,440 | 29,006 |
| Community development grant | 18,402 | 18,268 | 48,959 | 77,045 |
| Foundation grant | 20,000 | 25,000 | 25,000 | 0 |
| Capital contribution and donations | 0 | 0 | 0 | 451,999 |
| Total Public Support | 894,973 | 987,487 | 654,819 | 1,102,946 |
| Patient Revenue | | | | |
| Premiums for prepaid health plans | 607,028 | 199,787 | 47,634 | 0 |
| Medicare | 205,601 | 208,323 | 224,290 | 231,721 |
| Medi-Cal | 702,363 | 677,632 | 732,776 | 616,857 |
| Family planning | 33,166 | 36,925 | 39,508 | 39,667 |
| Private insurance | 33,842 | 60,589 | 79,831 | 81,212 |
| Patient direct | 209,825 | 160,428 | 230,503 | 243,994 |
| Child health and disability prevention program | 43,454 | 38,676 | 33,152 | 31,563 |
| Other | 6,984 | 2,915 | 9,918 | 3,771 |
| Patient Revenue | 1,842,263 | 1,385,275 | 1,397,612 | 1,248,785 |
| Less contractual allowances and adjustments | (455,898) | (330,943) | (349,705) | (348,352) |
| Net Patient Revenue | 1,386,365 | 1,054,332 | 1,047,907 | 900,433 |
| Total Revenue | 2,281,338 | 2,041,819 | 1,702,726 | 2,003,379 |
| Expenses | | | | |
| Salaries, wages, and benefits | 1,280,493 | 1,058,138 | 956,788 | 686,310 |
| Consultants and contracts | 484,018 | 378,234 | 290,758 | 349,244 |
| Supplies | 153,226 | 147,996 | 155,177 | 153,572 |
| Insurance and bonding | 85,979 | 124,113 | 128,059 | 96,379 |
| Utilities | 47,342 | 42,775 | 34,603 | 28,742 |
| Administrative | 35,508 | 41,775 | 33,892 | 51,129 |
| Rent | 32,200 | 24,478 | 19,695 | 0 |
| Repairs and maintenance | 31,541 | 20,369 | 24,204 | 22,284 |
| Computer service | 0 | 0 | 18,428 | 36,048 |
| Other expenses | 45,885 | 35,682 | 26,297 | 41,531 |
| Amortization of deferred charges | 15,413 | 17,587 | 8,662 | 0 |
| Interest expense | 48,788 | 48,386 | 17,781 | 10,052 |
| Depreciation | 57,119 | 56,385 | 43,245 | 38,825 |
| Provision for bad debts | 5,000 | 35,000 | 0 | 25,000 |
| Loss of disposal of fixed assets | 0 | 0 | 0 | 28,476 |
| Miscellaneous adjustment | (8,357) | 0 | 0 | 0 |
| Total Expenses | 2,314,155 | 2,030,918 | 1,757,589 | 1,567,592 |
| Excess of Revenue Over Expenses | $ (32,817) | $ 10,901 | $ (54,863) | $ 435,787 |

Note: The data for this table were taken from the center's audited financial statements for fiscal year 1985-86 through 1988-89. Audited financial statements are not available for fiscal year 1989-90.

# Appendix A-2 Comparative Balance Sheet Fiscal Year 1985-86 Through 1988-89

| | 1988-89 | 1987-88 | 1986-87 | 1985-86 |
|---|---|---|---|---|
| Assets | | | | |
| Current Fund | | | | |
| Cash on hand and in banks | 0 | 0 | 0 | $ 400 |
| Accounts receivable | $ 450,667 | $ 320,476 | $ 344,044 | 261,505 |
| Prepaid expenses | 1,717 | 36,805 | 34,495 | 5,656 |
| Inventory | 9,870 | 9,870 | 9,870 | 9,870 |
| Deferred charges | 6,188 | 21,037 | 35,887 | 0 |
| Fees and deposits | 22,411 | 22,975 | 6,082 | 0 |
| Total Current Fund | 490,853 | 411,163 | 430,378 | 277,431 |
| Fixed Asset Fund | | | | |
| Land | 162,000 | 162,000 | 162,000 | 162,000 |
| Building | 292,672 | 292,672 | 292,672 | 292,672 |
| Medical equipment | 129,974 | 126,042 | 124,212 | 97,154 |
| Office furniture and equipment | 124,560 | 123,250 | 97,841 | 127,229 |
| Computer equipment | 120,404 | 115,049 | 115,049 | 0 |
| Vehicles | 13,796 | 13,796 | 13,796 | 13,796 |
| Less allowance for depreciation | (289,847) | (232,728) | (176,343) | (133,098) |
| Total Fixed Asset Fund | 553,559 | 600,081 | 629,227 | 559,753 |
| Total Assets | $1,044,412 | $1,011,244 | $1,059,605 | $837,184 |
| Liabilities and Fund Balances (Deficiencies) | | | | |
| Current Fund | | | | |
| Current Liabilities | | | | |
| Checks written in excess of bank balances | $ 15,676 | $ 25,700 | $ 50,259 | $ 35,827 |
| Accounts payable | 176,259 | 146,206 | 175,356 | 190,560 |
| Contract advances | 37,000 | 37,000 | 34,000 | 10,827 |
| Accrued vacation pay | 38,587 | 41,169 | 41,169 | 31,783 |
| Notes and loans payable | 92,593 | 5,045 | 88,185 | 55,000 |
| Current portion of long-term debt | 36,023 | 40,112 | 51,300 | 13,500 |
| Total Current Liabilities | 396,138 | 295,232 | 440,269 | 337,497 |
| Long-term debt | 251,825 | 286,746 | 200,971 | 26,461 |
| Total Liabilities | 647,963 | 581,978 | 641,240 | 363,958 |
| Fund Balances (Deficiencies) | | | | |
| Current Funds | (157,110) | (170,815) | (210,862) | (86,527) |
| Fixed Assets Funds | 553,559 | 600,081 | 629,227 | 559,753 |
| Total Fund Balances | 396,449 | 429,266 | 418,365 | 473,226 |
| Total Liabilities and Fund Balances | $1,044,412 | $1,011,244 | $1,059,605 | $837,184 |

Note: The data for this table were taken from the center's audited financial statements for fiscal year 1985-86 through 1988-89. Audited financial statements are not available for fiscal year 1989-90.

Martin Luther King Jr. Family Health Center

101 Broadway • Richmond, California 94804 • (415) 233-3994

April 11, 1991

Kurt R. Sjoberg
Acting Auditor General
State of California
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Sjoberg:

A review of the draft report entitled "The Martin Luther King Jr., Family Health Center Needs to Improve Its Financial Operation," has been made. Preceding our comments on any particulars, we want to express our appreciation for the highly professional and humane manner in which the audit was conducted. The audit team was "great" in using the audit opportunity as a very constructive and helpful venture to assure maximizing the resources available to the Clinic.

Our general comment is that we basically agree with the overall report and recommendations, and we are well on our way towards implementing many of the specific recommendations. However, we do wish to share the following specific comments:

1. A new Board of Dirctors, and new administrative and clinical staff have been brought on board to restore the Center. In order to facilitate a more timely development of the Center's improvement plan and help these groups cope with the many deficiencies and at the same time establish good fiscal management practices, technical and expert assistance is essential. For example, the Center was able to produce in a miraculous time frame a viable financial plan with the technical assistance and expertise of the Contra Costa County Financial Officer and staff.

2. The Center should be provided funds and/or technical assistance in the following areas: Computer hardware, computer programming, Board responsibility training, funding and accounting protocol for the various granting sources, and fund development. Technical assistance is vitally important if the Center is to improve its fiscal and administrative operations in a more timely and effective manner.

3. The Center accepted a "catch 22" situation by beginning to reopen the Clinic before resolving the accounting and administrative deficiencies, in order to be able to obtain advance funding from the 330 Grant.

4. Funds that were anticipated were not made available on a timely basis. For example, the Center expected $210,000 in

September, 1990. Instead, only $110,000 was received in October, 1990. The Center was expecting $300,000 in December, 1990, but received it in March, 1991.

5. There should be a salary incentive program to encourage staff to remain with the Center. Until December, 1990, most positions had only one salary step. Thus, as soon as an employee became trained and gained experience at the Center, and these skills became marketable, the employee would leave for a better paying job. This seriously affects all areas: administration, clinical, fiscal, professional, technical, and clerical.

6. In order to begin to attract new clients, the Center should be provided special funds to develop a media and marketing program to counteract the negative image of the Center that has been created due to the financial crisis.

The myriad of problems encountered by the current administration is overwhelming, but not impossible to overcome. One of the biggest handicaps is the lack of state of the art equipment, and an insufficently trained technical staff. Nevertheless, the Board of Directors and the present staff are very committed to restoring the Clinic to a Center of Excellence in every respect.

Again, thank you for the opportunity to share these comments.

Sincerely,

Everett C. Davis, Ph.D.
Chairman,
Board of Directors

Julia Robinson-Ellis, FACHE,
Executive Director

JRE/gdc

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps